

Medication Therapy Management Training

Presenter : Vicky Murphy
Date : July 17, 2019



Agenda

- Overview
- Comprehensive Medication Review and Assessment (CMR/A)
- Qualifying Criteria for Members
- Procedure Codes and Modifiers
- Professional Claim Submission Options
- Direct Data Entry (DDE) Through the Portal
- Documentation Requirement

Overview

- The Medication Therapy Management (MTM) benefit consists of CMR/A services.
- CMR/A services are private consultations between a pharmacist and a member to review the member's drug regimen.
- BadgerCare Plus, SeniorCare, and Wisconsin Medicaid members are eligible to receive MTM services.
- Pharmacies are responsible for verifying the member's enrollment in one of the covered programs on the date of service the CMR/A is performed to receive reimbursement.

Overview (Cont.)

- SeniorCare will track and maintain the member spenddown or deductible amounts for claims for MTM services.
- SeniorCare will inform the pharmacy of the amount to charge the member through the remittance information.

Overview (Cont.)

- Members must be approved by ForwardHealth as someone who is at high risk of experiencing medical complications.
- The pharmacy requests approval to perform the CMR/A by calling the Drug Authorization and Policy Override (DAPO) Center.
- To perform CMR/A, the pharmacy and performing pharmacist are required to be Wisconsin Pharmacy Quality Collaborative certified, in addition to the pharmacy's enrollment in Wisconsin Medicaid.

CMR/A

CMR/A services are voluntary medication reviews for members performed by a pharmacist and may include the following value-added professional services:

- Obtaining the necessary assessments of the member's health status
- Formulating a medication treatment plan for the member
- Providing an updated personal medication record and medication action plan for the member following each CMR/A visit

CMR/A (Cont.)

- Providing information, support services, and resources to enhance member's adherence with a therapeutic regimen
- Providing verbal education and training to enhance the member's understanding and appropriate use of medication(s)
- Documenting the care delivered and communicating essential information to the member's primary care provider(s)
- Referring the member to an appropriate health care provider, if appropriate

CMR/A (Cont.)

- Coordinating and integrating medication management services within the broader health care system
- Notifying appropriate prescribers of each comprehensive care review and assessment service provided
- Sending a copy of the medication record and medication action plan to the prescriber
- Receiving authorization from specific prescriber if changes are needed for specific medications

CMR/A (Cont.)

- Identifying, resolving, and preventing medication-related problems
- Identifying medication-related problems, including adverse drug events, via either:
 - An initial face-to-face CMR/A
 - Performing medication reconciliation for a member discharged from a hospital or long-term care setting (with 14 days of discharge)
- Monitoring and evaluating the member's response to therapy with a follow-up CMR/A, including:
 - Safety
 - Effectiveness of target medications

Qualifying Criteria for Members

- A high-risk member meets one of the following criteria:
 - The member takes four or more prescription medications to treat or prevent two or more chronic conditions.
 - One of the member's chronic conditions must be hypertension, asthma, chronic kidney disease, congestive heart failure, dyslipidemia, Chronic Obstructive Pulmonary Disease, or depression.
 - The member has diabetes.
 - The member requires coordination of care due to multiple prescribers.

Qualifying Criteria for Members (Cont.)

- The member has been discharged from a hospital or long-term care setting within the past 14 days.
- The member has health literacy issues as determined by the pharmacist.
- The member has been referred for MTM services by the prescriber.

Qualifying Criteria for Members (Cont.)

- If the member meets at least one of the aforementioned criteria, the pharmacy must call the DAPO Center to request approval to provide CMR/A services.
- The CMR/A approval covers the initial and up to three follow-up CMR/As per rolling year.

DAPO Center Process

Information needed for DAPO processing:

- The member's name, date of birth, and Medicaid ID number
- Qualifying conditions, such as:
 - Chronic condition with medications
 - Health literacy
 - Diabetes
 - Referrals, provider or pharmacy
 - Discharge hospital or nursing home

DAPO Center Process (Cont.)

- Whether or not the member has received MTM services from this pharmacy before
- The pharmacy's NPI, phone number, and name
- The pharmacist's NPI
- The physician's NPI (if trying to qualify under Provider Referral)
- The requested start date

Procedure Codes and Modifiers

Each claim detail must include the appropriate *Current Procedural Terminology* (CPT) procedure code and modifier:

- 99605 UA New Patient (**Initial assessment** CMR/A visit; first 15 minutes)
- 99606 UA Established patient (**Initial assessment** CMR/A visit; first 15 minutes)
- 99607 UA (Additional 15 minutes)
- Limited to one initial assessment per rolling year

Procedure Codes and Modifiers (cont.)

Each claim detail must include the appropriate *Current Procedural Terminology* (CPT) procedure code and modifier:

- 99606 UB (Follow-up CMR/A visit; first 15 minutes)
- 99607 UB Additional 15 minutes
- Limit of 3 follow-up CMR/As during the rolling year of the override

Procedure Code and Modifiers (Cont.)

When submitting claims using procedure code 99607 (each additional 15 minutes), pharmacies should:

- List 99607 on the same claim as the primary service code (i.e., 99605 or 99606).
- List 99607 on a separate detail line from the primary service code.
- Enter units on the claim detail depending on the length of the visit.

Procedure Code and Modifiers (Cont.)

- Each 15 minutes is equal to one unit, for example:
 - 30 minutes equals two units.
 - 45 minutes equals three units.
- Round up to the nearest 15 minutes when determining the number of units to bill.

Procedure Code and Modifiers (Cont.)

- Claim details for procedure code 99607 are paid zero dollars since reimbursement for CMR/A services occurs with procedure code 99605 or 99606.
- Although procedure code 99607 will be reimbursed at zero dollars, pharmacies are required to submit details with the correct quantities to comply with correct coding practices.

Professional Claim Submission Options

Claims for CMR/A services must be submitted fee-for-service on a professional claim using a valid CPT code(s) and modifier via one of the following claim submission methods:

- 837 Health Care Claim transaction
- Provider Electronic Solution (PES) software
- DDE on the ForwardHealth Portal
- 1500 Health Insurance Claim Form

DDE Through the Portal

- DDE is an online application that allows providers to submit an individual claim or adjust a claim through their secure Portal.
- The following are advantages to using DDE:
 - The application is ready-to-use.
 - Providers receive real-time results.
 - The application provides automatic quality checks.
 - Technical assistance is available via the Portal Helpdesk at 866-908-1363.

DDE Through the Portal (Cont.)

For more information regarding the submission of professional claims through the Portal, refer to the Provider home page for links to the following:

- Portal User Guides
- Additional recorded MTM Trainings

DDE Through the Portal (Cont.)

Claim Status Information

Claim Status Not submitted yet

Submit Cancel

Claim Status Information

Claim Status PAY

Claim ICN 2211259001022

Paid Date 09/16/2011

Paid Amount \$11.91

EOB Information

Detail Number	Code	Description
1	9918	Pricing Adjustment - Maximum allowable fee pricing applied.

Cancel Adjust W Void Copy claim



Documentation Requirement

- ForwardHealth requires Pharmacy providers to submit MTM supplemental documentation and this can be done electronically using one of the following:
 - ForwardHealth-approved MTM case management software
 - The ForwardHealth Portal
- Providers are required to submit the associated MTM supplemental documentation electronically within 365 days of submitting the MTM claim.
- Providers are required to maintain on-site MTM supplemental documentation in the member's file.
- For assistance regarding the submission of MTM supplemental documentation on the portal, call the [ForwardHealth Portal Helpdesk](#) or refer to the [Medication Therapy Management Documentation Storage User Guide](#).

Resources

- ForwardHealth Portal: www.forwardhealth.wi.gov/
- Provider Services: 800-947-9627
 - Pharmacy — for drug claim, policy, and drug authorization inquiries

Resources (Cont.)

Provider Relations Representative for MTM services

- **Teresa Heusel**

teresa.heusel@wisconsin.gov

(512) 319-4137

Counties - Milwaukee, Dodge, Washington, Ozaukee, Jefferson, Waukesha, Rock, Walworth, Racine, Kenosha

- **Jennifer Watts**

jennifer.watts@wisconsin.gov

(608) 421-6116

Counties - Marathon, Portage, Waushara, Marquette, Green Lake, Winnebago, Calumet, Manitowoc, Fond du Lac, Sheboygan

- **Natalie Stone**

natalie.stone@wisconsin.gov

(608) 421-6040

Counties- La Crosse, Monroe, Juneau, Adam, Vernon, Richland, Sauk, Crawford, Grant, Iowa, Dane, Columbia, Iowa, Lafayette, Green

- **Kyle Robel**

kyle.robelt@wisconsin.gov

(608) 421-6275

Counties - Florence, Forest, Marinette, Langlade, Menominee, Oconto, Shawano, Waupaca, Outagamie, Brown, Kewaunee, Door

- **Natalie Stone**

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(608) 421-6040

Counties - Douglas, Bayfield, Ashland, Iron, Vilas, Burnett, Washburn, Sawyer, Price, Oneida, Lincoln, Taylor, Rusk, Barron, Polk, St. Croix, Dunn, Chippewa, Clark, Eau Claire, Pepin, Pierce, Buffalo, Trempealeau, Jackson



Resources (Cont.)

For assistance regarding the submission of MTM supplemental documentation on the Portal:

- Refer to the Medication Therapy Management Documentation Storage User Guide.
- Call the Portal Helpdesk 866-908-1363.

Thank You